



Benefit Levels	In Network Coverage Level	Out of Network Coverage Level
Calendar Year Deductible	No Deductible	\$5000.00 Deductible
Out of Pocket Maximum	\$6,500.00 Individual and 17,100.00 Family for in network charges <b>ONLY</b> . Out of Network expenses and pre-certification penalties do not apply.	
Wellness/Preventive Care	100% for all Preventative Services	In Network Only
Adult Physical Examination	100%	In Network Only
Well Child Exams	100%	In Network Only
Routine GYN Exams	100%	In Network Only
Mammogram / Prostate Screening / Bone Density	100%	In Network Only
Routine Eye Exam (One per year)	100%	In Network Only
Immunizations, Including: Flu, Pneumonia, Shingles	100%	In Network Only
Routine Colonoscopy and EGD Testing	100%	In Network Only
<b>Supplemental Accident Benefit - Treatment must be within 90 days following the accident.</b>		
Charges must be reported as an accident on a claim form	100% up to \$300.00 then regular in network or out of network benefits apply.	
Second Surgical Opinion (Required for certain procedures)	100% Coverage	
Smoking Cessation	100% Coverage	
<b>Physician Services - General or Family Practice, Pediatrician, OB/GYN, Internal Medicine or Urgent Care Clinic</b>		
Includes services rendered only by that doctor during that visit	\$30.00 co-pay per visit	Deductible then 50%
Maternity - Physician Fees (dependent children not covered)	\$400.00 co-pay/Pregnancy	Deductible then 50%
Urgent Care Clinic	\$30.00 co-pay per visit	\$30.00 co-pay per visit
<b>Specialist Office Visit - Oncologist, Neurologist, Optometrist, Chiropractor, Dermatology, Cardiology etc.</b>		
Includes services rendered only by that doctor during that visit	\$40.00 co-pay per visit	Deductible then 50%
<b>In office items without Office Visit</b>		
In office injection w/out office visit billed	\$40.00 co-pay per visit	Deductible then 50%
Minor in office surgery w/out office visit billed	\$40.00 co-pay per visit	Deductible then 50%
Allergy testing w/out office visit billed	80% coverage	Deductible then 50%
Hearing/audiology testing in office w/out office visit billed	80% coverage	Deductible then 50%
Quest Select Benefit - Independent Network	100% Coverage	In-Network Only
<b>Free Standing Lab / Radiology Clinic / Physician charges excluding office visit</b>		
Baseline x-rays or labs other than Lab One	\$30.00 co-pay	Deductible then 50%
MRI, Pet Scan, Sleep Study, Hida Scan	\$250.00 co-pay	Deductible then 50%
Ct Scan	\$100.00 co-pay	
Echo cardiogram, EKG, EMG, stress test, halter monitor, ultrasound, diagnostic mammogram at Imaging Center	\$30.00 co-pay	Deductible then 50%
<b>Lab / Radiology done at Facility (Hospital or Outpatient Surgery Center)</b>		
Baseline x-ray or labs	\$30.00 co-pay	Deductible then 50%
MRI, Pet Scan, Sleep Study, Hida Scan	\$250.00 co-pay	Deductible then 50%
CT Scan	\$100.00 co-pay	
Echo cardiogram, EKG, EMG, stress test, halter monitor, ultrasound, diagnostic mammogram	\$30.00 co-pay	Deductible then 50%
<b>Physical / Occupational / Speech Therapy</b>		
PT clinic or home	\$40.00 co-pay/visit	Deductible then 50%
Facility	\$40.00 co-pay/visit	Deductible then 50%
Hospice	100%	Deductible then 50%
Home Health Care	\$40.00 co-pay/visit	Deductible then 50%
Chemotherapy / Radiation / Dialysis	\$75.00 co-pay/visit	Deductible then 50%
Cardiac Rehab	\$40.00 co-pay/visit	Deductible then 50%
<b>Durable Medical Equipment</b>		
DME in office with office visit	80%	Deductible then 50%

DME from DME supplier	80%	Deductible then 50%
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## HOSPITAL SERVICES

Emergency Room Services	\$100.00 co-pay per visit	\$100.00 co-pay per visit
Emergency Room Physician and All Related Charges	100%	100%
Out Patient Hospital /Ambulatory Surgery Center Procedures (other than diagnostic procedures listed above)	\$275.00 co-pay per visit	Deductible then 50%
In Patient Hospital Admission	\$350.00/day co-pay, max of 5 days	Deductible + \$500 co-pay, then 50% coverage
Maternity Inpatient Facility Fees	Same as any inpatient stay	Deductible + \$500 co-pay, then 50% coverage
Hospital Related Charges: Physician, Radiology & Anesthesiology	100%	Deductible then 50%
Ambulance Services	Ground Transport \$50 co-pay; Air Transport \$250 co-pay	Ground Transport \$50 co-pay; Air Transport \$250 co-pay

Prescriptions (If drug costs less than co-pay amount, you pay the lesser amount)		
Deductible	\$250.00 Deductible	In-Network Only
Pharmacy Dispensed		
Generic	\$20.00 co-pay	In-Network Only
Preferred Brand Name	\$35.00 co-pay	In-Network Only
Non-Preferred Brand Name	\$70.00 co-pay	In-Network Only
- Mail Order	90 day supply for 2 co-pays	In-Network Only
Generic Mail Order	\$40.00 copay	In-Network Only
Preferred Brand Mail Order	\$70.00 copay	In-Network Only
Non-Preferred Brand Mail Order	\$140.00 copay	In-Network Only

Organ Transplant		
Recipient	\$500.00 inpatient copay/day maximum 5 days	In-Network Only
Associated Costs	Subject to regular benefits	In-Network Only

Mental Health Care / Alcohol and Drug : Covered the same as any other illness		
Inpatient & Residential Treatment	\$300.00/day Maximum of 5 days	Deductible then 50% coverage
Hospital related charges: physician, radiology	100%	Deductible then 50% coverage
Office Visit and Partial Hospitalization	\$30.00	Deductible then 50% coverage

*Please see attached for complete listing or contact CCMSI for further information*

Required for surgical procedures or non-emergency hospital admission In-Network or Out-of-Network.  
 All Emergency admissions in and out of Network must be reported and approved within 48 hours of the admit.  
 Also, required for certain outpatient procedures including: MRI, Physical Therapy & Durable Medical Equipment  
 Chemotherapy/Radiation Treatment, Dialysis Treatment, Out-patient Surgery.  
 Pre-certification is required at least 48 hours prior to any procedures.  
***Failure to pre-certify will result in the denial of the claim***

**Eligibility - All full time employees working 30 hours or more per week.**

Elected officials and retirees may participate if designated an eligible class by the Group. Eligible dependents include legal spouses and dependent children up to the age of 26.

**Non-Network Benefits :**All out of network benefits are subject to review for reasonable and customary fees. Any difference in the amount charged and the amount allowed will be the responsibility of the member. Eligible Expenses from a Non-Network provider are determined based on: Fees that are negotiated with the provider, a percentage of published rates that are allowed by Medicare for the same or similar service, 50% of the billed charge or a fee schedule that we develop.

**PPO Network: Verity Health Network**

[WWW.VERITYHEALTH.COM](http://WWW.VERITYHEALTH.COM)

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